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ABSTRACT

Home Based Family Centered (HBFC) services give primary responsibility for evaluation, service planning, and counseling to the direct service in-home family therapist. In the mental health center (MHC), the psychiatrist may see a child once in the office and make a diagnosis and recommendation for the child, and sometimes for the parents. Also in the MHC, the tendency has been to assign an in-home worker to lower socio-economic families, principally for purposes of gaining information and for encouraging the family to bring one of its children to the MHC offices. This reflects an historical preference for serving the individual in the office and the low priority given to serving the poor, hard to reach, hard core, chronic, and unmotivated. Often mental health centers are clinically, administratively, and sometimes geographically divided into child, adolescent, and adult divisions. From a family systems perspective this is not useful. Interactional processes as a part of the treatment program are sacrificed. The psychiatric, medical influence of the mental health center emphasizes pathology or dysfunction. The HBFC therapist is looking for competence and how to elicit and enhance what strengths a parent, child, or family has to solve their own problems. These issues point to a need for HBFC services to continue to serve as separate, distinct, and clearly defined approaches to prevention and remediation in work with families. (LLL)

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WHY MENTAL HEALTH CENTERS SHOULD NOT DO HOME-BASED FAMILY CENTERED SERVICES

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WHY MENTAL HEALTH CENTERS SHOULD NOT DO HOME-BASED FAMILY CENTERED SERVICES

INTRODUCTION

Funding for increased investment in families has encouraged a variety of agencies to provide some type of service to children (and/or their families) who live at home. Some of these services were already in place and were simply relabeled to fit current terminology. Some are delivered by agencies created principally or solely to provide an alternative to children about to be placed away from home. Others have added some form of "in-home" service as an adjunct to existing services. With no standards for practice and the eventual DHHS phrase "reasonable effort" left undefined, anyone could do anything and call it whatever.

WHAT'S IN A NAME

In the 1950's, St. Paul termed its home-based family centered program "family centered."(1) In the late 40's, the Mendota Mental Health Institute developed a program to work with children, their parents and the school as an alternative to hospitalization and called it "home community treatment".(2) In the early 1970's a number of programs were created for the same purpose--to provide families with an alternative to placement. Among these were Families, Inc. in Iowa, Lower East Side Family Union in New York City, Homebuilders in Tacoma, Washington, Association for Jewish Children of Philadelphia, and Youth Services, Inc. also in Philadelphia.(3)

When the National Clearinghouse for Home-Based Services was created at the University of Iowa, with the assistance of the Department of Health and Human Services, Social Rehabilitation Services, in 1977, the phrase home-based family centered services was coined and defined to refer to these various programs and the approach to service delivery.(4) During the past decade, several variations of the phrase have appeared. These include "community based services, home based services, family based services, family preservation services and intensive family preservation services". This abberation of terminology makes it difficult to

communicate meaningfully about what we do simply by using a name. In this paper, Home Based Family Centered services refers to a way of thinking, which shapes the treatment programs and includes the following characteristics:

1. The family is the focus of service.
2. The family's home is the primary service base.
3. The therapist maintains a family systems and ecological perspective.
4. Client assessment and services are keyed to needs of the family in its environment, rather than services available in the agency.
5. Caseloads are small enough to permit counselors to work several hours a week with the family when needed.
6. Well-trained, confident, highly motivated in-home family therapists provide the therapy.

HOME BASED FAMILY CENTERED SERVICES IN MENTAL HEALTH CENTERS

ORGANIZATIONAL CONSIDERATIONS

Most mental health centers have a hierarchy of organization. Home Based Family Centered services gives primary responsibility for evaluation, service planning and counseling to the direct service in-home family therapist. This is essential to the Home Based Family Centered services counselor's credibility with the family. Immediate availability and intimate frequent contact is with the Home Based Family Centered services therapist. The Home Based Family Centered services therapist is the one who has continuous up-to-date awareness of the family's dynamics and interaction processes, knows current needs, and has first-person information based on frequent observations and personal contacts. These factors are present in the horizontal organization often found in Home Based Family Centered services programs, where administration is decentralized and the family and the in-home therapist dictate treatment directions.

STRUCTURAL CONSIDERATIONS

Staff roles tend to be prescribed in mental health centers. Most are staffed with several disciplines, each with its own theoretical frame of reference and terminology. These disciplines often engage in a sophisticated competitive process, vieing for status, work assignment, office space, etc. Usually, these issues are resolved to the extent that the business at hand gets conducted. Each discipline proceeds to do its own thing with the multi-disciplinary approach, which does not constitute teamwork. Such structuring does not work well if the family is the client. The problems may parallel the family's conflict, or exacerbate or create factions in the family and/or community.

In the mental health center, the psychiatrist may see a child once in the office and make a diagnosis and recommendations for the child and sometimes for the parents. Decisions made on the basis of an interview and observation in the office are not the same as a HBFCS therapist's decisions and recommendations based on contacts with the family in the home, 2-3 times a week for a month or more.

POLITICAL CONSIDERATIONS: A MATTER OF SURVIVAL

Home Based Family Centered services have sometimes been added onto an already complex organizational structure and given status equal to the perceived importance of their particular constituent population.

In mental health centers, the tendency has been to assign an in-home worker (usually less qualified than in-office personnel) to lower socio-economic families, principally for purposes of gaining information and for encouraging the family to bring one of its children to the MHC offices. This reflects an historical preference for serving the individual in the office and the low priority given to serving the "poor, hard to reach, hard core, chronic, unmotivated", etc.

The seductive but strong nature of a larger working system is to encourage conformity for fitting into the mental health center mode of operation. This makes

it difficult for the Home Based Family Centered services approach to be accepted, valued, and adopted as an agency approach. Some Home Based Family Centered services components, tacked onto existing bureaucracies, have struggled for survival. Meantime, the national alliance for the mentally ill reports that 1 out of every 4 hospital beds is occupied by a "mental patient" at a cost of $72.7 billion.(5) One must wonder if all these folks are characterized by "seriously distorted reality orientation" or whether hospitalization is often a matter of convenience and payment. One client reported to the authors that she was faced with choosing between a week in the hospital and a week's vacation.

TECHNICALLY AND CHRONOLOGICALLY CORRECT BUT PRACTICALLY NOT USEFUL CONSIDERATIONS

Often mental health center's are clinically, administratively, and sometimes geographically divided into children, adolescent, and adult divisions. This practice may be technically correct in that there are different issues and abilities between age groups. It may also be efficient to classify individuals by age. But from a family systems perspective, it is practically not useful. Other family members become simply reporters. Interactional processes as a part of the treatment program are sacrificed. Reliance upon second and third party information, usually days or weeks old, is increased. The larger content of family and community inter-agency interactional processes, which may serve to cause or maintain the family's problems, may be overlooked. Heath observes that the majority of seriously emotionally disturbed children and adolescents are still being treated from an individual orientation without any family intervention.(6) His experience as a reviewer of grant applications to the NIMH suggests a lack of awareness of other options.

FOCUS OF TREATMENT CONSIDERATIONS

It is ironic that the mental health center name implies health while the emphasis of programs are on problems. The psychiatric, medical influence emphasises pathology or dysfunction. Rather than focus on family strengths, resources and abilities there is a concentration on deficits. This typically involves individual repression of feelings and history as being causal which results in dysfunction and inadequacy/incompetence. The Home-Based Family Centered therapist is looking for competence and how to elicit and enhance what strengths a parent, child or family has to solve their own problems. This effects the type of intake, assessment procedures, the length of treatment and the effectiveness of treatment. All are at odds with the standard theoretical orientation and procedural processes of the mental health center.

The HBFC therapist may even ask the family to reflect on how the therapist is doing and construct new directions for treatment themselves as a means of empowering and respecting the family's abilities. Construction of solutions based on exceptions to the problems that have occurred in the past, present or hypothetical future possibilities provides the family with self-initiative which respects their own unique cultural values and personal abilities.(7) The therapist wants to know how the parent or referring worker will know when the problem is solved.

A DIAGNOSTIC CONSIDERATION

Diagnostic evaluations, such as the DSM IIIR, categorizes problems and creates the illusion that there is such a thing as an evaluation and assessment period. That this has to be done before treatment begins, rather than viewing the therapist as being involved with and having an effect on this family and vice versa.(8) Treatment has already begun, whether it is recognized or not, by the therapists

presence in the home, the type of questions that are asked, how these questions are perceived by the family and how the worker perceives the family are already influencing the course of future treatment. Usually diagnosis means extensive family history taking which confirms symptoms, changes nothing and makes for long term treatment.

Such diagnostic labeling creates or promotes permanent traits rather than transient states. The HBFC therapist is looking to promote a sense of normalcy given the life circumstances, frames difficulties in light of relationships and phases of development which have a beginning and end. The HBFC therapist does not view the family as something to be observed and examined for analysis but rather as a constantly changing group. The emphasis is on treating the person, not the diagnosis. In addition, doing intake, evaluation and diagnosis with focus on the individual encourages and/or reinforces scapegoating and makes it very difficult to begin family therapy, should this be the treatment of choice.(9)

TACK-ON PROGRAMS

Home-based family centered services program components are relatively easily added. Space is not an issue since HBFCS personnel usually work out of their homes. There is comparatively little overhead. Job responsibility can be easily shifted to another department. The home-based family centered services program is often merely an appendage of a much larger system that operates under a different set of theoretical concepts and values. These programs are often referred to as "projects". The mission of the larger agency is often not family oriented and sometimes not "home or community" based. In whose interest is the program provided: The agency? The family? The dominant profession? The funds available via adoption of the name? Even in the best of situations, the home-based family centered services program component supports the larger organization by sharing the administrative costs. In addition, the focus and commitment, even the program, can change overnight with a new administrator or supervisor who may have another priority.

A REPLICATION CONSIDERATION

Are the families you serve different from those of the program you are replicating? Often programs are being replicated with little consideration for the context of the families that will be served. A 45 day program that every family has to accept with x number of sessions every week, with a prescribed/structured approach of how to do an interview with every family will not be effective. Additionally, the HBFC therapist sees families that oftentimes need more than traditional psychotherapy. Service considerations need to be made for educational needs (child and parent/s), job training and employment, financial, recreational and medical resources that are available for the family. This requires a flexible and adaptable working model of service provision that is supported by staff and administration.(10)

The HBFC worker individualizes the treatment program to fit the family rather than trying to make the family fit the treatment program. The worker starts where she/he can get the most immediate results! There is no one single simple explanation for why a family experiences problems and similarly there is no one way to bring about resolution. There are many ways to accomplish a treatment goal and often these can be accomplished in a surprising and creative manner. For example one couple having conflict over where to move, stated that they kept moving from city to city because one or the other of them was always in disagreement about the move. The move was either too close to one or the others parents/relatives, no jobs available, etc. The therapist instructed them to sit down together and use assertive communication skills to express their ideas to each other. He came back a week later to find the couple smiling about how they had reached agreement about where to move for the first time in their marriage. The therapist asked how their discussion had gone, to which they replied, "Oh, we never did any of that." In disbelief the worker asked how they had come to such unanimous consensus. They

described how they had laid out on the living room floor a large map of the United States and that each of them blindly tossed two darts each on the map. Then drew lines connecting where both of their darts had landed and the point at which the two lines intersected was where they were going to move.

A STRATEGIC CONSIDERATION

What would families themselves say about who provides the service? This may be one of the most important, if not the most important consideration of all. If a service is going to be provided it is logical to expect that it be provided by an agency and in a manner that will be most accepted by the families themselves. To do otherwise would be to create resistance that is not necessary. From the family's point of view they may be very distrustful of the "mental health system", especially if they have generational issues where the parent or grandparent had received psychiatric services as a child or has continued to receive services as an adult. Often the Mental Health Center is associated with medication and psychiatric hospitalizations. Families can and often are fearful that their children will be removed or treated in a similar fashion. While this may or may not be a valid fear it is one less barrier for an independent agency to have to overcome in relating to the family.

CONCLUSION

Based on the considerations outlined in this article, the authors propose that there are problems inherent in the provision of Home-Based Family Centered Services within most Mental Health Centers. Important considerations are reviewed and implications as to who and how HBFCS are provided, are considered. The authors maintain that Home-Based Family Centered Services should continue to serve as a separate, distinct, and clearly defined approach to prevention and remediation in work with families.

BIBLIOGRAPHY

1. Horejsi, C. The St. Paul Family Centered Project Revisited: Exploring an Old Gold Mine. In M. Bryce & J. Lloyd (Eds.) Treating Families in the Home: Alternative to Placement. Springfield, Il., Charles C. Thomas, 1981, 12-23.

2. Fahl, M. & Morrisey, D. The Mendota Model: Home Community Treatment. In S. Maybanks & M. Bryce (Eds.) Home-Based Services for Children & Families: Policy, Practice & Research. Springfield, Il., Charles C. Thomas, 1979, 225-236.

3. A review of these and other similar program may be found in the book referenced in 2 above.

4. Bryce, M. Home Based Care: Development and Rationale. In S. Maybanks & M. Bryce (Eds.) Home-Based Services for Children and Families. Springfield, Il., Charles C. Thomas, 1979, 20.

5. National Alliance for the Mentally Ill. Facts about mental illness. Arlington, Va., NAMI, 1983.

6. Heath, A. Family Therapy Discovers the Secrets of NIHM. In Family Therapy News, July/August, 1990, 5.

7. DeShazer, S. Clues: Investigating Solutions in Brief Therapy. New York, N.Y., W. W. Norton, 1988, 1-9.

8. Dell, P. & Meyerstein, I. Family Therapy Versus Schizophrenia and the Psychiatric-Legal Establishment. In S. Coleman (Ed.) Failures in Family Therapy. New York, N.Y., Guilford Press, 1985, 241-273.

9. Haley, J. Why A Mental Health Clinic Should Avoid Family Therapy. In Reflections on Therapy and Other Essays. Chevy Chase, Md., The Family Therapy Institute of Washington D.C., 1981, 174-189.

10. Duchnowski, A. & Freidman, R. Family-Centered Services: Implications for Mental Health Administration and Research. In Children's Mental Health Services, Journal of Mental Health Administration. Vol. 17, No. 1., 1990, 13-25.